HOUSTON FIRE DEPARTMENT

VERIFICATION OF HEALTH CARE PROVIDER VISIT FOR NON-OCCUPATIONAL INJURY / ILLNESS

SECTION 1 SHALL BE COMPLETED BY THE EMPLOYEE

Name _____ (LAST) _____ (FIRST) _____ (MIDDLE)

PAYROLL _____ RANK OR TITLE _____

SHIFT _____ DEBIT _____ STATION OR WORK LOCATION _____

☐ EMPLOYEE INJURY OR ILLNESS EMPLOYEE PHONE CONTACT _____

☐ SICK FAMILY MEMBER RELATIONSHIP TO EMPLOYEE _____

☐ WELLNESS OFFICE VISIT

SECTION 2 SHALL BE COMPLETED BY THE HEALTH CARE PROVIDER

NAME OF HEALTH CARE PROVIDER _____

HEALTH CARE PROVIDER ADDRESS _____

HEALTH CARE PROVIDER PHONE NUMBER _____

DATE OF OFFICE VISIT _____

DATES OF ABSENCES COVERED _____

DATE OF SIGNATURE _____

HEALTH CARE PROVIDER SIGNATURE _____

SECTION 3 SHALL BE COMPLETED BY HEALTH CARE PROVIDER

DATE EMPLOYEE RELEASED TO **FULL DUTY** WITHOUT RESTRICTIONS _____

OR

DATE EMPLOYEE RELEASED TO **LIMITED DUTY** WITH RESTRICTIONS _____

EMPLOYEE IS **RESTRICTED** FROM THE FOLLOWING: (CHECK ALL APPLICABLE BOXES)

☐ LIFTING ☐ REACHING ☐ CLIMBING ☐ BENDING OR KNEELING

☐ STANDING ☐ USE OF ARM (L) OR (R) ☐ USE OF LEGS (L) OR (R)

☐ OPERATE / WORKING NEAR EQUIPMENT

☐ ADDITIONAL RESTRICTIONS _____

SECTION 4 SHALL BE COMPLETED BY RECEIVING DISTRICT CHIEF OR EQUIVALENT RANK

DATE RECEIVED _____ TIME RECEIVED _____

SUPERVISOR NAME _____ PAYROLL _____

SIGNATURE _____

SECTION 5 TO BE CONSIDERED VALID THE FORM 48 MUST:

HAVE SECTIONS 1 AND 2 COMPLETED (FOR EMPLOYEE'S FAMILY MEMBER'S CONDITION);
HAVE SECTIONS1, 2 AND 3 COMPLETED (FOR EMPLOYEE'S OWN CONDITION);
COVERED ALL DATES OF ABSENCES;
BE SIGNED BY A HEALTH CARE PROVIDER AS DEFINED IN APPENDIX A;
BE SUBMITTED WITHIN SIX (6) CALENDAR DAYS (EXCLUDING THE INITIAL DATE OF REQUESTED LEAVE) AND EVERY THIRTY (30) CALENDAR DAYS THERAFTER FOR THE DURATION OF THE BONA FIDE NON-OCCUPATIONAL ILLNESS, DISEASE, OR INJURY.